Request for Access to Inspect or Copy Record
from the Washington State Employee Assistance Program

Date:_____ Client ID #: _____

Client's Name: _____ Birth Date: _____

_____
Address to Send Copy of Record or Summary

I am requesting access to my designated record set for the following purpose:

☐ I wish to review my record as follows (indicate date and time):

_____

☐ I am requesting a copy of the following portion of my record:

_____

☐ I am requesting a copy of my entire record:

☐ I would like to have a summary of my record, subject to agreement by:_____
Name of EAP Counselor

I understand that I may be charged a reasonable cost-based fee for this copy of my record, portion of my record, or a summary of my record and that the EAP may withhold my copy (format requested above), until this fee is paid. The agreed-upon fee for my request specified above is $ _____ .

I understand my record or summary will be provided to me in a paper format; that I will be informed if my record or requested portion of my record does not exist or cannot be found; that if the EA Professional does not maintain my requested record or portion of that record, he or she will inform me (if known) of the health care provider who does maintain my record.

I understand my request may be granted or denied. In either event, my request will be responded to as promptly as required under the circumstances, but no later than 15 working-days after receiving this request. In the event that unusual circumstances delay my request, I will be informed in writing of the reasons for the delay and of the earliest date (not later than 21 working-days after my request) that my records will be available for examination or copying, or when my request will be otherwise disposed.

_____ _____
Signature of Client *Date*

_____ _____
Signature of Client's Personal Representative/parent (if applicable) *Date*

For Office Use Only

Date Request Received: _____ Request Response Due Date: _____

6 Working Day Extension Enacted? ☐ Yes ☐ No ☐ Client Informed Date: _____

New Required Response Date _____

Action Taken (check one) ☐ Granted ☐ Denied If denied state reason: _____

_____ _____
*Signature of EAP Representative** *Date*

**If not signing in the presence of an EAP Representative, see page 2 for instructions*

In lieu of coming in-person to the EAP office with an ID to receive a copy of the record, a client may sign this form in the presence of a notary. **Note**: The Employee Assistance Program may require additional information to ensure the accuracy of this information provided.

I understand that if I do not complete and return this form, my request will be denied.

You must complete and sign this form in the presence of a notary.

Please Note: Any person who requests or obtains confidential information and records related to mental health services pursuant to this chapter under false pretenses is guilty of a gross misdemeanor (RCW 70.02.330 Obtaining confidential records under false pretenses—Penalty)

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct and that I am the individual requesting access to inspect or copy my own records.

_____

Client Signature Date

_____

Client Printed Name

_____

Address

To be completed by a Licensed Notary Public:

Name of Notary:_____

Signed or Attested before me on:_____day of_____month of _____year.

_____

Signature of Notary Date My Appointment Expires

Seal or Stamp: